

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08883

★ Reg. Dist. No. 70

1. PLACE OF DEATH:

County Cassell
 City or town Amesbury, Tarrytown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Transient
 Hospital, institution, or street address where death occurred:
Woods - Amesbury Shook Farm
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 225 E. Third St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

William H. Abrecht
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Lela W. Shuff
 7. Birth date of deceased (mo., day, yr.) December 23, 1886
 6.(c) If alive, give age _____ years
 8. AGE: Years 59 Months 8 Days 24 hrs. _____ min. _____
 9. Birthplace Frederick, Frederick - Md
 (Town, county, and state)
 10. Usual occupation Cardmaker
 11. Industry or business Cemetery

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown
 16. Informant Mrs John G. Huffman
 Address Woodboro, Maryland
 17. Burial Date thereof 9/20/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mount Olivet Cemetery
 Location Frederick, Maryland
 18. Funeral director M. R. Etchison & Son
 Address Frederick, Maryland

19. Sept. 17 19 46 Mary B. Wilt
 (Date rec'd by registrar) (month) (day) (year) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 19 46 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____
 and that I last saw h. _____ alive on _____ 19____

Immediate cause of death Personary occlusion

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

_____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

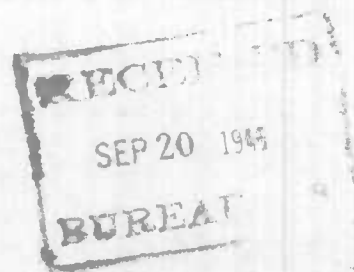
Injured at home, farm, industry, public place (where?) _____

Mens of injury _____ Injured at work? _____

23. SIGNATURE James P. Thone Deputy Medical Examiner
 M. D. or other _____

Address Westminster Md Date signed 7-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 882

CERTIFICATE OF DEATH

08884

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
City or town near Gamber
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Carroll
City or town near Gamber
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Anna D. Arnold

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Married
B.(b) Name of husband or wife E. Bayard Arnold
B.(c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) November 29, 1895
8. AGE: Years 50 Months 9 Days 12 If less than one day
.....hrs.min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946, at 5pm
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Sept 10 1946
and that I last saw him alive on Sept 10 1946

Immediate cause of death cerebral hemorrhage
DURATION 2 days

Due to arteriosclerosis 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R. Font M.D. or other

Address Westminster, Md Date signed 9-11-46

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name John T. Derr

13. Birthplace Maryland

14. Maiden name Carrie Fowler

15. Birthplace Maryland

16. Informant E. Bayard Arnold

Address Gamber, Md.

17. burial Date thereof 9/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Pleasant Cem.

Location Gamber, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 9/11 46 H Wood
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 13 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 14 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1109 South Race Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

CARRIE AVERY

3.(b) Social Security Number

220-22-5404

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 16, 1922 6.(c) If alive, give age _____ years

8. AGE: Years 23 Months 10 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Gastonia, N. C.
(Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business

12. Name John Avery

13. Birthplace Unknown

14. Maiden name Mary Parker

15. Birthplace Unknown

16. Informant Deceased

Address

17. Shipped Date thereof 9-17-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gastonia

Location North Carolina

18. Funeral director Isaac L. Brown & Co.

Address 108 W. Montgomery St.

19. 9/15 46 Alfred R. Swannhaus
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1946, 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1945 to Sept. 15, 1946 and that I last saw him/her alive on September 15, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION March 1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Neuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 9/15/46

RECEIVED

SEP 17 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No.

08886



70

1. PLACE OF DEATH:

County Carroll
 City or town Rural Taneytown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
 City or town _____
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Ida H. Patson

3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife George Batson

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1866

8. AGE: Years 80 Months 0 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Pa.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Richard Crouse
 13. Birthplace Md

14. Maiden name Margaret Schaeffer
 15. Birthplace Md.

16. Informant Mrs. Wilson Crouse
 Address Keymar, Md.

17. Burial Date thereof Sept 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Kriders
 Location Near Westminster, Md.

18. Funeral director C.O. FUSS & SON
 Address Taneytown, Md.

19. Sept 22 46 Ethel M. McKim
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Sept 2 1946
 and that I last saw him alive on Sept 19 1946

Immediate cause of death arterio sclerosis
mental degeneration

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. W. Legg M. D. or otherAddress Union Bridge Date signed 9-21-46

RECEIVED

SEP 25 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08887

Reg. Dist. No. 74

1. PLACE OF DEATH:

County.....Carroll
 City or town.....Rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, one month
 Hospital, institution, or street address where death occurred:
 Springfield State Hospital
 How long in hospital or institution? 2 years, one month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County Allegany
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edward F. Bechtol

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) June 8, 1877
 8. AGE: Years 69 Months 3 Days 5 If less than one day
 hrs. min.

9. Birthplace Morgan County, W. Virginia
 (Town, county, and state)
 10. Usual occupation telegraph operator
 11. Industry or business railway
 12. Name James Edward Bechtol
 13. Birthplace West Virginia
 14. Maiden name Mary Ann Wheet
 15. Birthplace West Virginia

16. Informant Springfield State Hospital Records
 Address Sykesville, Maryland
 17. Burial Date thereof 9-16-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rosemont Cemetery
 Location Berkeley Springs, W. Va.
 18. Funeral director Walter Stedman Home
 Address Cumberland, Md.
 19. Sept 13 1946 C. Harry Weiss
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 13 1946 at 3:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Aug. 13 1944 to Sept. 13 1946
 and that I last saw him alive on Sept 12 1946

Immediate cause of death General Paralysis of the Insane
 DURATION 4 yrs.

Due to.....
 Due to.....

Other conditions Psychosis with syphilitic meningoencephalitis
 (Include pregnancy within 3 months of death)
 DURATION 4 yrs.

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.
 Spring State Hospital M. D. or other
 Address Sykesville, Maryland Date signed 9-13-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 18 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08888

Reg. Dist. No. *82*

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, 5 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 4 monts, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
 City or town New Windsor, Penna
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Shantown Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Howard Lee Caylor

3. (b) Social Security Number

None

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 3/9/1881
 8. AGE: Years 65 Months 6 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
 12. Name Abram Caylor
 13. Birthplace Maryland
 14. Maiden name Metilda Cover
 15. Birthplace Virginia

16. Informant Records of Springfield State Hosp.
 Address Sykesville, Maryland

17. Burial Date thereof Sept 17 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Deep Creek Cemetery
 Location Shantown Road

18. Funeral director D. D. Hartzel & Sons
 Address New Windsor & Union Bridge road
Sept 15 1946
 (Date rec'd by registrar) Registrar Ernest Skunkel

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1946, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/29/46 1946 to 9/14 1946
 and that I last saw him alive on 9/14 1946

Immediate cause of death _____ DURATION _____

Coronary Thrombosis institution
 Due to _____

Due to _____

Other conditions Psychosis & Cerebral Arteriosclerosis 9 months
 (Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arnold H. Eichert, M.D.

Address Springfield State Hospital Date signed 9-14-46

RECEIVED

SEP 19 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-

08889

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County... Carroll
City or town... Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County...
City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 923 Argyle Avenue
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3. (a) FULL NAME

GEORGE COLE

3. (b) Social Security Number

579-16-1187

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 19, 1922
8. AGE: Years 24 Months 6 Days 22 If less than one day hrs. min.

9. Birthplace... New York, N.Y.
(Town, county, and state)
10. Usual occupation... Tailor
11. Industry or business

FATHER
12. Name... Frank Cole
13. Birthplace... Unknown
MOTHER
14. Maiden name... Edna Ware
15. Birthplace... Washington, D. C.

18. Informant... Mrs. Hattie Banks
Address... 506 Pine St., Balto., Md.

17. Burial Date thereof 9/14/46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory... Mt. Auburn
Location... Balto Md.

18. Funeral director... Wm. A. Jackson
Address... 916 perma ave. Balto Md

19. 9/10 46
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1946, at 6.50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 3, 1946 to Sept. 10, 1946 and that I last saw him alive on Sept., 10, 1946

Immediate cause of death... Pulmonary Tuberculosis
DURATION June 1946

Due to...
Due to...
Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...
Date of op. ...

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE... Neuker Hoffman, M. D.
M. D. or other
Address... Henryton, Md Date signed 9/10/46



COPY SENT TO LOCAL REGISTRATION OFFICE Co. H. Officer DATE 9/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

08890

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs, 4 mos, 4 days.
 Hospital, institution, or street address where death occurred:
Springfield State Hosp.
 How long in hospital or institution? 5 yrs, 4 mos, 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Clarksburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -----
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

MARGARET CORDELL

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Welly C. Cordell
 6.(c) If alive, give age 46 years
 7. Birth date of deceased (mo., day, yr.) August 24, 1912
 8. AGE: Years 34 Months 0 Days 21 If less than one day ----- hrs. ----- min.

9. Birthplace Bristol, Va.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business own home
 FATHER 12. Name Kenny Lytton
 13. Birthplace Virginia
 MOTHER 14. Maiden name Bertha ----
 15. Birthplace Virginia

16. Informant Hospital Records
 Address -----

17. Burial Date thereof Sept 17 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Clarksburg
 Location Montgomery Co Md
 18. Funeral director Ray W. Barber
 Address -----
 19. Sept 15 1946 C. Harry Elms
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1846 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1941 to Sept 15 1846
 and that I last saw her alive on Sept. 15, 1946 1846

Immediate cause of death

Pulmonary Tuberculosis

DURATION

6 mos.

Due to

Due to

Other conditions

Schizophrenia, Hebephrenic type8 years.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eickert, M.D.

M. D. or other

Address S. S. Hosp. Sykesville, Md. Date signed 9-15-46

RECEIVED
SEP 17 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

08891

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County.....Carroll
City or town.....Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 20 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....Maryland County.....Baltimore
City or town.....Ruxton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carrollton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Howard Frank Ecker

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Sarah E. Gone
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 14, 1885
8. AGE: Years 61 Months 4 Days 4 hrs. min.

9. Birthplace New Windsor, Maryland
(Town, county, and state)
10. Usual occupation Parcel room clerk
11. Industry or business railroad
12. Name John W. Ecker
13. Birthplace New Windsor, Maryland
14. Maiden name Susan Long
15. Birthplace New Windsor, Maryland

16. Informant Springfield State Hospital Records
Address Sykesville, Maryland
17. Burial Date thereof 9-21-46
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory Sam's Creek Cem.
Location Carroll Co. Md.
18. Funeral director William Cook, Jr.
Address 1217 St Paul St.
19. Sept 19 1946 C. H. H. W. W. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946 at 9:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 1945 to Sept. 18 1946
and that I last saw him alive on September 18 1946

Immediate cause of death Arteriosclerosis DURATION 7 yrs.
Due to.....
Due to.....
Other conditions Psychosis with cerebral arteriosclerosis 7 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?
Robert Bertrand May, M.D.
23. SIGNATURE Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Sykesville, Maryland Date signed 9-19-46

MARGIN RESERVED FOR BINDING

VS-415 9-45-15

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 24 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

08892

Reg. Diat. No.

70

1. PLACE OF DEATH:

County Carroll
 City or town Taneytown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____
 City or town _____
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Margaret L. Englar

3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife P.B. Englar

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1860
 6. (c) If alive, give age _____ years

8. AGE: Years 85 Months 11 Days 28 It less than one day _____ hrs. _____ min.

9. Birthplace Md
 (Town, county, and state)

10. Usual occupation housework

11. Industry or business _____

12. Name Henry Reindollar13. Birthplace Md14. Maiden name Mary Buffington15. Birthplace Md16. Informant Miss Beulah EnglarAddress Taneytown, Md.

17. Burial Date thereof Sept. 30, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LutheranLocation Taneytown, Md.18. Funeral director C. O. FUSS & SONAddress Taneytown, Md.

19. Sept 30 1946 Ethel M. Mehner
 (Dated by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27th 19 46 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 32 to Sept. 19 46

and that I last saw him alive on September 26th 19 46

Immediate cause of death Cerebral hemorrhage
(Cerebral hemiplegia) DURATION 15 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ethel M. Mehner M. D. or other

Address Taneytown, Maryland Date signed 9/28/46

RECEIVED
OCT 2 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

08893
Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 23 days

Hospital, institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 4 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Preston
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lloyd Douglas Fooks

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife Anna May LeCompte

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1903

8. AGE: Years 43 Months 7 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Preston, Caroline, Maryland
(Town, county, and state)10. Usual occupation Service worker

11. Industry or business _____

12. Name E. Lloyd Fooks13. Birthplace Maryland14. Maiden name Mary Douglas15. Birthplace Maryland16. Informant Hospital Records Md.Address Springfield State Hosp., Sykesville,17. Burial Date thereof Sept. 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FederalburgLocation Federalburg, Md.18. Funeral director J. Virgil Moore & SonAddress Deale, Md.19. Sept. 18, 1946 Registrar C. Henry Edges
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1946, at 5:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1946, to Sept. 18, 1946and that I last saw him alive on September 18, 1946

Immediate cause of death _____ DURATION

Pulmonary Tuberculosis 6 mos.

Due to _____

Due to _____

Other conditions _____

Schizophrenia, Paranoid type 12 years
(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arnold H. Eichert, M.D. M. D. or otherAddress 1414 W. 14th St., Hyattsville, Md. Date signed 9-18-46

RECEIVED
SEP 19 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 088976
 ★ Reg. Dist. No.

1. PLACE OF DEATH: County..... <u>Carroll</u> City or town..... <u>Westminster</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Carroll</u> City or town..... <u>Westminster</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>169 E. Green St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Frances E. Fringer</u>				3. (b) Social Security Number _____			
4. Sex <u>female</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>single</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife _____				20. DATE OF DEATH <u>September 18</u> 19 <u>46</u> at <u>1.30 PM</u>			
7. Birth date of deceased (mo., day, yr.) <u>May 3, 1860</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Feb. 17</u> 19 <u>46</u> to <u>Sept. 18</u> 19 <u>46</u> and that I last saw him alive on <u>Sept. 17</u> 19 <u>46</u>			
8. AGE: Years..... <u>86</u> Months..... <u>4</u> Days..... <u>15</u> If less than one day..... hrs. min.		6. (c) If alive, give age years		Immediate cause of death <u>Carcinoma of Liver</u>			
9. Birthplace <u>Westminster, Maryland</u> (Town, county, and state)				DURATION <u>about 4 mos.</u>			
10. Usual occupation <u>none</u>				Due to			
11. Industry or business FATHER 12. Name..... <u>George N. Fringer</u> 13. Birthplace..... <u>Maryland</u>				Due to			
MOTHER 14. Maiden name..... <u>Catherine Hoff</u> 15. Birthplace..... <u>Maryland</u>				Other conditions <u>Senility - Nephritis</u> (Include pregnancy within 3 months of death)			
16. Informant <u>Guy N. Fringer</u> Address..... <u>Westminster, Md.</u>				Major findings of operations Date of op.			
17. Burial (Burial, cremation, or removal. Which?)..... <u>burial</u> Date thereof..... <u>9/21/46</u> (month) (day) (year) Cemetery or crematory..... <u>Westminster Cemetery</u> Location..... <u>Westminster, Md.</u>				Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
19. Funeral director <u>J. Francis Reese</u> Address..... <u>Westminster, Md.</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
19. <u>9/19</u> <u>46</u> (Date rec'd by registrar)				23. SIGNATURE <u>C. T. Billingsley, M.D.</u> M. D. or other Address..... <u>Westminster, Md.</u> Date signed..... <u>9-18-46</u>			

Registrar

RECEIVED

SEP 21 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 88876

1. PLACE OF DEATH:

County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo.
Hospital, institution, or street address where death occurred:
128 E. Green St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Fred.
City or town Rural New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Ida Greenwood

3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Isiah Greenwood

7. Birth date of deceased (mo., day, yr.) March 20 1858 6.(c) If alive, give age _____ years

8. AGE: Years 88 Months 3 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Fred. Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Era Trotter

13. Birthplace Fred. Co. Md.

14. Maiden name Not known

15. Birthplace

16. Informant Mrs. Harry Greenholtz
Address 128 E. Green, Westminster, Md.

17. Burial Date thereof Sept. 19-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood Cemetery
Location New Windsor, Md. R.D.

18. Funeral director H. B. Anderson & Son

Address Westminster, Md.

19. 9/18/46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Sept 15 1946 and that I last saw her alive on Sept 15 1946

Immediate cause of death Generalized Arteriosclerosis

DURATION

yr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE James V. Throckm. D. M. D. or other

Address Westminster, Md. Date signed 9/18/46

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 20 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08896

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... CarrollCity or town... Sylkesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... CarrollCity or town... Sylkesville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Edna Knox Hawkins

3. (b) Social Security Number

4. Sex

W.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Walter L. Hawkins

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Jan. - ? - 1881

8. AGE:

Years

Months

Days

If less than one day

658?

hrs.

min.

9. Birthplace

MD.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Henry Knox

13. Birthplace

MD.

MOTHER

14. Maiden name

Mary Gill

15. Birthplace

MD.

16. Informant

Mr. Walter L. Hawkins

Address

Sylkesville, MD.

17.

(Burial, cremation, or removal: Which?)

Date thereof

Sept. 20, 1946
(month) (day) (year)

Cemetery or crematory

Springfield Cemetery

Location

Sylkesville, MD.

18. Funeral director

C. Harry Green

Address

Sylkesville, MD.

19.

(Date rec'd by registrar)

Sept. 19, 1946C. Harry Green

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1941to deathand that I last saw him alive on September 18 1946

Immediate cause of death

Embolicus of the Coronary artery following operation

DURATION

Due to

Due to

Other conditions

adenocarcinoma of gall bladder

(Include pregnancy within 3 months of death)

3 mon

Major findings of operations

multiple adenocarcinoma of gall bladder

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Lawrence, M.D.

M. D. or other

Address: Sylkesville Date signed 9/18/46

RECEIVED
SEP 24 1945
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 08897 71

1. PLACE OF DEATH

County **Carroll**
 City or town **Linwood Rural**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **Lifetime**
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Carroll**
 City or town **Linwood Rural**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Uniontown Road**
 (If rural, give LOCATION)
 2.(a) If veteran, name war **None**

3. (a) FULL NAME

Edward Hawn

3. (b) Social Security Number

None

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife **Mrs Gertrude Hawn**
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) **August 20-1868**
 8. AGE: Years **78** Months **1** Days **0** If less than one day _____ hrs. _____ min.

9. Birthplace **Carroll County Maryland**
 (Town, county, and state)

10. Usual occupation **Farmer**11. Industry or business **Retired**12. Name **John W Hawn**13. Birthplace **Maryland**14. Maiden name **Mary Shriner**15. Birthplace **Maryland**16. Informant **Earl W Hawn**Address **Westminster, Maryland**

17. **Burial** Date thereof **Sept 22-1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Lutheran Cemetery**Location **Uniontown, Maryland**18. Funeral director **D.D.Hartzler & Sons**Address **Union Bridge & New Windsor Md**

19. **9/22/46** 19 **46** **Margaret Plungla**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 20-1946** 19 **46** **A.M**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **19 43** to **Sept 20** 19 **46**
 and that I last saw him alive on **Sept 20** 19 **46**

Immediate cause of death

Arteriosclerotic C-V disease

DURATION

Years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE **James F. Thorne M.D.** M. D. or otherAddress **Westminster Md** Date signed **9-21-46**

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08898

74

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 11 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County

City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 704 Cumberland St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

HORTENSE HENRY

3. (b) Social Security Number

4. Sex female 5. Color or race col. 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 20, 1919 6.(c) If alive, give age

8. AGE: Years 27 Months 0 Days 6 If less than one day

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name William Henry13. Birthplace Virginia14. Maiden name Dorothy White15. Birthplace Virginia16. Informant Deceased

Address

17. Burial Date thereof Sept. 28, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. AuburnLocation Baltimore, Md.18. Funeral director Geo. E. KelownAddress 1303 Chestnut Street

19. Sept. 26, 1946
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1946 at 12:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1946 to Sept. 26, 1946
 and that I last saw him er alive on Sept. 26, 1946

Immediate cause of death Pulmonary Tuberculosis
 DURATION Jan. 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE Robert H. Fuman, M.D.

Henryton, Md. M. D. or other
 Address

Date signed 9-26-46

RECEIVED
OCT 3 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County... Carroll
City or town... Leabro, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Pa County... York
City or town... Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No... Leabro #2
(If rural, give LOCATION)
2.(a) If veteran, name war...

3.(a) FULL NAME

James M. Hetrick

3.(b) Social Security Number

4. Sex Male 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife... Hester Houch

Oct. 8 - 1874 6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 8 - 1874

8. AGE: Years 71 Months 11 Days 2 If less than one day
..... hrs. min.

9. Birthplace... York Pa
(Town, county, and state)

10. Usual occupation... Farm Labour

11. Industry or business

12. Name... Emmanuel Hetrick

13. Birthplace... Pa

14. Maiden name... Angeline Subbs

15. Birthplace... P.

16. Informant... Clatus Hetrick

Address... Leabro, Md. #2

17. Buried Date thereof... Sept 13 1946
(Burial, cremation, or removal of body?) (Month) (day) (year)

Cemetery or crematory... Sherman Church

Location... Hanover, Pa. P.D

18. Funeral director... H. Joseph & Son

Address... Glenn Park, Pa

19. Sept 12 19 46 Mrs. W. P. I. Deener
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 10 19 46 at 5.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dr. J. H. Decker 19 46
and that I last saw him alive on 19 46

Immediate cause of death... Coronary Thrombosis

DURATION Systemic Death

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

.....Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Yes

Means of injury Injured at work? Yes

Maurice C. Porter
Acting Deputy Med. Examiner

23. SIGNATURE W. P. I. Deener M. D. or Ch.D.

Address... Hanover, Md. Date signed 9-12-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 19 1946
BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08900

74

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs., 10 mos., 10 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Caroline
 City or town Denton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

ROLAND HUBBARD

3. (b) Social Security Number

213-18-4525

4. Sex male 5. Color or race col. 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 21, 1921
 8. AGE: Years 25 Months 3 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Denton, Md.
 (Town, county, and state)
 10. Usual occupation Ship Yard Laborer
 11. Industry or business _____
 12. Name Minos Hubbard
 13. Birthplace Caroline County, Md.
 14. Maiden name Bessie Smith
 15. Birthplace Caroline County, Md.

16. Informant Reuben Hoffman, M.D.
 Address Henryton, Md.

17. Burial Date thereof Sept. 22, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Grove Cem.
 Location Denton, Maryland

18. Funeral director J V Moore
 Address Denton Md

19. Sept. 19, 46
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 46 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 42 to Sept. 19, 46 and that I last saw him alive on Sept. 19, 46

Immediate cause of death Pulmonary Tuberculosis DURATION Oct. 1942

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 9-19-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 26 1946
B. B. F. A. L. - B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Carroll
 City or town..... near Uniontown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 mos
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Carroll
 City or town..... near Uniontown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Emile Huet

3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... MC

6.(b) Name of husband or wife..... Emma M. Huet

7. Birth date of deceased (mo., day, yr.)..... 8.(c) If alive, give age..... years

8. AGE: Years..... 67 Months..... 3 Days..... 5 If less than one day..... hrs. min.

9. Birthplace..... Balto
 (Town, county, and state)

10. Usual occupation..... Farming11. Industry or business..... no12. Name..... Agustine Huet13. Birthplace..... Balto14. Maiden name..... Anna Wagner15. Birthplace..... Hartford Ct16. Informant..... Mrs Emma M. HuetAddress..... Union Bridge Rd17. burial Date thereof..... Sept 10, 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Western CemLocation..... Balto Md.18. Funeral director..... George J. NeubauerAddress..... Reisterstown Md.19. 9-10 19. 10
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 9 1946 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 8 1946 to Sept 9 1946and that I last saw him alive on Sept 8 1946

Immediate cause of death.....

Carcinoma of Stomach

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... J. N. Legg M. D. or otherAddress..... Union Bridge Date signed 9-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No.

08902

1. PLACE OF DEATH:

County..... Carroll

City or town..... Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yr., 1 mo., 16 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 14 yr., 1 mo., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1934 Walbrook Ave.
(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (a) FULL NAME

Harry C. Hutchinson

3. (b) Social Security Number

none

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Nora Lee Blake

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 28, 1892

8. AGE: Years Months Days If less than one day

54 5 5 hrs. min.

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 3, 1946, 5:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to Sept. 3, 1946

and that I last saw him alive on September 2, 1946

Immediate cause of death Coronary occlusion

DURATION instant

Due to.....

Due to.....

Other conditions Dementia Precox, paranoid type

(Include pregnancy within 3 months of death) 16 yrs.

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.

Springfield State Hospital
Sykesville, Maryland

M. D. or other

Address..... Date signed 9-3-46

9. Birthplace Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation Street car conductor (retired)

11. Industry or business

12. Name James Hutchinson

13. Birthplace Baltimore City, Maryland

14. Maiden name Ruth Reisinger

15. Birthplace Baltimore City, Maryland

16. Informant Springfield State Hospital Records

Address Sykesville, Maryland

17. Burial Date thereof 9/6/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Sept 5 1946 A. G. Hedrick
(Date rec'd by registrar) per Ruth Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08903

Reg. Dist. No. 24

1. PLACE OF DEATH: County <u>Carroll</u> City or town <u>Sykesville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 years, 1 month</u> Hospital, institution, or street address where death occurred: <u>Springfield State Hospital</u> How long in hospital or institution? <u>4 years, 1 month</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore City</u> City or town <u>1459 Woodall Street, Baltimore, Md.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) <input checked="" type="checkbox"/> 2.(a) If veteran, name war _____			
3.(a) FULL NAME <u>Margaret Irwin</u>				3.(b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Divorced</u>			
6.(b) Name of husband or wife <u>Clarence Irwin</u>							
7. Birth date of deceased (mo., day, yr.) <u>2/2/1893</u>							
6.(c) If alive, give age <u>?</u> years							
8. AGE: Years <u>53</u>		Months <u>7</u>		Days <u>4</u>		If less than one day _____ hrs. _____ min.	
9. Birthplace <u>Maryland</u> (Town, county, and state)							
10. Usual occupation <u>Housewife</u>							
11. Industry or business							
12. Name <u>Andrew Hemerich</u>							
13. Birthplace <u>Germany</u>							
14. Maiden name <u>Susan Schafer</u>							
15. Birthplace <u>Maryland</u>							
18. Informant <u>Records of Springfield State Hospital</u> Address <u>Sykesville, Maryland</u>							
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Sept 6, 1946</u> (month) (day) (year) Cemetery or crematory <u>Holy Redeemer</u> Location <u>Baltimore, Md.</u>							
18. Funeral director <u>Mr. Charles Stevens</u> Address <u>1501 E. Fort Ave.</u>							
19. Date <u>Sept 6, 1946</u> Registrar <u>C. Harry Green</u> (Date rec'd by registrar)							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>September 6, 1946</u> at <u>6:45 A.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>August 6, 1946</u> to <u>Sept 6, 1946</u> and that I last saw him <u>er</u> alive on <u>9/6/1946</u> Immediate cause of death <u>Pulmonary Tuberculosis</u> <u>(Tuberculous Pneumonia)</u> Due to _____ Other conditions <u>Involuntal Melancholia</u> (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of Injury _____ Injured at work? _____							
23. SIGNATURE <u>Arnold H. Eichel M.D.</u> <u>Springfield State Hospital M. D. or other</u> Address <u>Sykesville, Maryland</u> Date signed <u>9/6/46</u>							

SEP 10 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

08904

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 3 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. 4.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

ELLA LOUISE JACKSON

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) April 5, 1923 6. (c) If alive, give age..... years
 8. AGE: Years 23 Months 5 Days 8 If less than one day..... hrs. min.

9. Birthplace Frederick County, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Welford Weadon
 13. Birthplace Frederick County, Md.

MOTHER 14. Maiden name Gertrude Bowens
 15. Birthplace Frederick County, Md.

16. Informant Welford Weadon
 Address R.F.D. #4, Frederick, Md.

17. Buried Date thereof 9-16-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Sumner Side Cemetery
Near Adamstown Md
 Location

18. Funeral director M. R. Etchison & Son
Frederick, Md
 Address

19. 9/13 19 46 Albert R. Swannell
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 19 46 11.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 19 46 to Sept. 13, 19 46
 and that I last saw her alive on September 13, 19 46

Immediate cause of death Pulmonary Tuberculosis
 DURATION Nov. 1
1945

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Raymond Hoffman M.D. M. D. or other

Address Henryton, Md Date signed 9/13/46

RECEIVED

SEP 19 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08905

CERTIFICATE OF DEATH



Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 3 mos., 14 days.
 Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium (Colored)
 How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No 321 South Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war --

3. (a) FULL NAME

FLORENCE MAY JOHNSON

3. (b) Social Security Number

182-20-4985

4. Sex <u>Female</u>	5. Color or race <u>colored</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
6. (b) Name of husband or wife		
6. (c) If alive, give age _____ years		
7. Birth date of deceased (mo., day, yr.) <u>January 3, 1920</u>		
8. AGE: Years <u>26</u>	Months <u>7</u>	Days <u>28</u>
If less than one day _____ hrs. _____ min.		

9. Birthplace Easton, Md.
 (Town, county, and state)
 10. Usual occupation factory worker
 11. Industry or business

MOTHER FATHER
 12. Name Charles Howard
 13. Birthplace Easton, Md.
 14. Maiden name Catherine Miller
 15. Birthplace Easton, Md.

16. Informant Reuben Hoffman, M.D.
 Address Henryton, Md.
 17. Burial Date thereof Sep 4, 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Richard Cem.
 Location Easton Md
 18. Funeral director R. Ellis Clark
 Address Easton Md.
 19. Sept. 1, 1946
 (Date rec'd by registrar) Alfred P. Swank deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 46 at 7:45a. AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945 to Sept. 1, 1946
 and that I last saw her alive on Sept. 1 19 46

Immediate cause of death Pulmonary tuberculosis
 DURATION 4/6/45
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
 M. D. or other
 Address Henryton, Md. Date signed 9-1-46

RECEIVED

SEP 9 1946

BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

CERTIFICATE OF DEATH

08906

Reg. Dist. No. 7X

1. PLACE OF DEATH:

County Carroll
 City or town Springfield State Hospital
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs., 7 mos., 6 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 18 yrs., 7 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Woodlawn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ?
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Sadie C. Jones

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Ashby Jones
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug. 27, 1871
 8. AGE: Years 75 Months — Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Christman

13. Birthplace Virginia

14. Maiden name Jeannette Ann Christman

15. Birthplace Virginia

16. Informant Hospital records

Address _____

17. Burial Date thereof 9/19/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location Taylor Ave.

18. Funeral director William J. Tickner & Sons

Address North & Pa. Aves.

19. 9/18 19 46 Geo Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 19 46 at 1:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11, 19 28 to Sep. 17, 19 46

and that I last saw her alive on Sep. 16, 19 46

Immediate cause of death
Chronic myocarditis DURATION 7 yrs.
Generalized arteriosclerosis 7 yrs.

Due to Cerebral thrombosis 3 mos.

Due to _____

Other conditions Fracture of right hip 2 mos.

Due to: Accidental fall Rever
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 16, 1946

Where did injury occur? Springfield State Hospital
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Accidental fall Injured at work? _____

23. SIGNATURE Joseph H. Marshall, M.D.
 M. D. or other _____

Address Springfield State Hosp. Date signed 9-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 7 mos., 1 day
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
 How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1129 N. Gilmore Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

John Kiah

3. (b) Social Security Number

4. Sex male 5. Color or race col. 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 30, 1915
 8. AGE: Years 31 Months 3 Days 23 If less than one day hrs. min.

9. Birthplace Anne Arundel County, Md.
 (Town, county, and state)
 10. Usual occupation Selling papers
 11. Industry or business

FATHER
 12. Name Vernon Kiah
 13. Birthplace Unknown
 MOTHER
 14. Maiden name Madeline Kiah
 15. Birthplace Unknown

16. Informant Deceased
 Address

17. Burial Date thereof 9/25/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Metropolitan Cemetery
 Location A. A. Co. Md.

18. Funeral director Metropolitan Funeral Home
 Address 927 N. Mount St.
9-23- 46 Albert R. J. J. J.

19. (Date rec'd by registrar) 19 46 Albert R. J. J. J.
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1946 at 12:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22, 1945 to Sept. 23, 1946
 and that I last saw him alive on Sept. 23, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION Sept. 10, 1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 9-23-46

RECEIVED
SEP 25 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08908

74

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 months, 10 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Turners Station
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 103-A Morten Court
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

EVA LAWS

3. (b) Social Security Number

4. Sex female 5. Color or race col. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 7, 1920
 8. AGE: Years 26 Months 2 Days 21 If less than one day hrs. min.

9. Birthplace North Carolina
 (Town, county, and state)
 10. Usual occupation Reiveter
 11. Industry or business
 FATHER 12. Name Edward McCoy
 13. Birthplace Unknown
 MOTHER 14. Maiden name Katie ?
 15. Birthplace North Carolina

16. Informant Deceased
 Address 322 N. Schorader St.
 17. mt A. Brown Date thereof 10/2/1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory mt A. Brown
 Location Westport
 18. Funeral director Mrs. Katie R. Williams
 Address 322 N. Schorader St.
 19. Sept. 28, 1946 Wm. R. Swann
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1946 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 18, 1945 to Sept. 28, 1946
 and that I last saw her alive on Sept. 28, 1946

Immediate cause of death
Pulmonary Tuberculosis

DURATION
Aug. 1, 1945

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE Reuben M. M. D. M. D. or other
Henryton, Md. Date signed 9-28-46
 Address.....

RECEIVED
OCT 3 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Diat. No. 08909 76

1. PLACE OF DEATH:

County... Carroll Co.City or town... near Westminster
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:

Carroll County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... CarrollCity or town... near Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No. County Home
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Leese

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m. w. single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 18748. AGE: Years Months Days If less than one day
72 4 19 hrs. min.9. Birthplace Potomac, Carroll Co., Md.
(Town, county, and state)10. Usual occupation laborer

11. Industry or business

12. Name John H. Leese13. Birthplace Wash. Co., Md.14. Maiden name Maggie Arthur15. Birthplace Fred. Co., Md.16. Informant George Bankert, AgentAddress County Home, Westminster, Md.17. Burial Date thereof Sept. 14, 1944
(Burial, cremation, or removal. Which?) (Month) (day) (year)Cemetery or crematory County Home CemeteryLocation near Westminster, Carroll Co., Md.18. Funeral director J. S. Myers, Jr.Address Westminster, Md.19. 9/14/46 Registrar J. S. Myers, Jr.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13- 1946 at 4-8 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-13- 1946 to 9-13- 1946 and that I last saw him alive on 9-12- 1946

Immediate cause of death

Cerebral arteriosclerosis DURATION 3 mksDue to arteriosclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Shriver M. D. or otherAddress Westminster Date signed 9-14-46

CERTIFICATE OF DEATH

1946

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of witness

10. Signature of funeral director

11. Signature of undertaker

12. Signature of coroner

13. Signature of justice of the peace

14. Signature of health officer

15. Signature of city clerk

16. Signature of county clerk

17. Signature of state clerk

18. Signature of federal clerk

19. Signature of postmaster

20. Signature of telegraph operator

21. Signature of telephone operator

22. Signature of newspaper editor

23. Signature of publisher

24. Signature of printer

25. Signature of binder

26. Signature of distributor

27. Signature of collector

28. Signature of agent

29. Signature of salesman

30. Signature of clerk

31. Signature of messenger

32. Signature of porter

33. Signature of janitor

34. Signature of cook

35. Signature of waiter

36. Signature of barman

37. Signature of bartender

38. Signature of bartender

39. Signature of bartender

40. Signature of bartender

RECEIVED
SEP 16 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (842)

CERTIFICATE OF DEATH

Reg. Dist. No. 0891074

1. PLACE OF DEATH:
County..... Carroll
City or town..... Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years 7 months 6 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 31 years 7 months 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md. County..... Garrett
City or town..... Parkland
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Albert G. Lipscomb

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... Unk.
6. (b) Name of husband or wife..... Daisy
7. Birth date of deceased (mo., day, yr.) March 21, 1868 6. (c) If alive, give age..... years
8. AGE: Years..... 78 Months..... 5 Days..... 21 If less than one day..... hrs. min.

9. Birthplace..... Garrett Co. Md.
(Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business

12. Name..... Thomas P. Lipscomb
13. Birthplace..... W. Va.

14. Maiden name..... Elizabeth Rodehever
15. Birthplace..... Garrett Co. Md.

16. Informant..... Springfield State Hosp Records
Address..... Sykesville, Md.

17. Burial Date thereof..... 9-15-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Oakland
Location..... Garrett Co. Md.

18. Funeral director..... Baldwin Funeral Home
Address..... Parkland, Md.

19. Sept 12 1946 C. Henry Wilson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 12 19 46 at 10:55 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 4, 1946 19 46 to September 12 19 46
and that I last saw him alive on September 12 19 46

Immediate cause of death..... senility DURATION..... 10 years

Due to.....

Due to.....

Other conditions..... paranoid condition 32 years

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Howard N. Fredericksen M.D.
M. D. or other

Address..... Sykesville, Md. Date signed..... Sept 12, 46

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
SEP 16 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3316 Ellerslie Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Lloyd

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widower6.(b) Name of husband or wife Sadie Davis Lloyd7. Birth date of deceased (mo., day, yr.) 2/14/1870

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7676

hrs.

min.

9. Birthplace Harford County, Maryland
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

FATHER
MOTHER12. Name Robert W. Lloyd13. Birthplace Virginia14. Maiden name Hub -15. Birthplace Maryland16. Informant Records of Springfield State HospitalAddress Sykesville, Maryland17. Burial Date thereof Sept 23, 1946
(Burial, cremation, or removal - Which?) (month) (day) (year)Cemetery or crematorium State Ridge CemeteryLocation Delta, Pa.18. Funeral director August P. PerkinsAddress Delta, Pa.19. Sept 21 19 46 C. Harry Eaves
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 19 46 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 10, 1946 to Sept. 20 19 46and that I last saw him alive on Sept. 20 19 46

Immediate cause of death

DURATION

Pneumonia 10 days

Due to

Due to

Other conditions Psychosis - cerebralAnterior lobe

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eickert M.D.
M. D. or otherAddress Dr. H. E. Eickert, M.D. Date signed 9-20-46

RECEIVED
SEP 24 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08912 74

1. PLACE OF DEATH:

County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 1 mo. 17 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 S. Schroeder St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

TILDIE McCULLOUGH

3. (b) Social Security Number

4. Sex male 5. Color or race col. 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1891

8. AGE: Years 55 Months 0 Days 21 If less than one day hrs. min.

9. Birthplace Great Falls, S.C.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Tildie McCullough

13. Birthplace South Carolina

14. Maiden name Maggie White

15. Birthplace South Carolina

16. Informant Deceased

Address

17. Stripped Date thereof 9/24/1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory great falls

Location

18. Funeral director Mrs. Kate R. Williams

Address 322 N. Schroeder Street

19. Sept. 21, 1946 Albert R. Shookman
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1946 7:00A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4, 1942 to Sept. 21, 1946 and that I last saw him alive on Sept. 21, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION July 6, 1942

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 9-21-46

RECEIVED
SEP 28 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

08913

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County... Carroll
 City or town... Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 years
 Hospital, institution, or street address where death occurred:
Methodist Protestant Church Home
 How long in hospital or institution? 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Carroll
 City or town... Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... East Main Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Virginia Helen Moores

3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife... None
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) May 21, 1869
 8. AGE: Years 77 Months 3 Days 24 If less than one day
 hrs. min.

9. Birthplace... Maryland
 (Town, county, and state)

10. Usual occupation... none

11. Industry or business

12. Name... Samuel L. Moores
 13. Birthplace... Maryland

14. Maiden name... Frances Old
 15. Birthplace... Maryland

16. Informant... Mrs. George K. Mather
 Address... Westminster, Md.

17. burial Date thereof... 17 Sept. 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Protestant Episcopal Cem.
 Location... Reisterstown, Md.

18. Funeral director... Walter Brooks Bradley
 Address... 1922 W. North Ave. Balto. Md.

19. (Date rec'd by registrar) 19... L.R. Woodward
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 14 1946, at 3 p. M

21. I CERTIFY that death occurred on the date above stated; that I advised deceased from 40. Sept. 14 1946
 and that I last saw him alive on Sept. 14 1946

Immediate cause of death... Cerebral Hemorrhage
 Due to... Arteriosclerosis 9 yrs

Other conditions...
 (Include pregnancy within 8 months of death)

Major findings of operations... Date of op.

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... L.R. Woodward M. D. or other
 Address... Westminster Date signed... 9/14/46

RECEIVED

SEP 16 1946

BUREAU V 8

proposed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08914
76

1. PLACE OF DEATH:

County.....CARROLL

City or town.....WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND..... County.....CARROLL

City or town.....WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)Street No.....289 E. MAIN ST.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

EDWARD B. ORNDORFF

3. (b) Social Security Number

NONE

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife.....GRACE ORNDORFF

7. Birth date of deceased (mo., day, yr.)

SEPT. 16, 1879

8. AGE: Years Months Days If less than one day

67 0 11 hrs. min.

9. Birthplace.....WESTMINSTER, MD.
(Town, county, and state)

10. Usual occupation.....LABOR

11. Industry or business

12. Name.....JOSEPHUS A. ORNDORFF

13. Birthplace.....MARYLAND

14. Maiden name.....MARIA L. BUCKLEY

15. Birthplace.....MARYLAND

16. Informant.....MRS. GLOYD LYNCH

Address.....WESTMINSTER, MD.

17. BURIAL Date thereof.....9/30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....ST. JOHN'S CATHOLIC CEMETERY

Location.....WESTMINSTER, MD.

18. Funeral director.....J. FRANCIS REESE

Address.....WESTMINSTER, MD.

19. Date rec'd by registrar.....SEPT 28 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....SEPT. 27, 1946, at.....9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1943 to Sept 27, 1946
and that I last saw him alive on Sept 26, 1946

Immediate cause of death.....Tuberculosis (ch) (Palm)

DURATION

seven
years-

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....None

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....None Date of.....

Where did injury occur?.....None
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

23. SIGNATURE.....W. C. Jermuth MD,

M. D. or other

Address.....Westminster Date signed.....9-27-46

RECEIVED
OCT 4 1946
BURLAND V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08915

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CarrollCity or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Minnie Lewis Osborne

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Andrew Osborne

7. Birth date of

deceased (mo., day, yr.)

Feb.

6. (c) If alive, give age

17years
1875

8. AGE:

Years

Months

Days

If less than one day

71620

.....hrs.

.....min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Henderson Lewis

13. Birthplace

N. C.

MOTHER

14. Maiden name

Nancy Vanover

15. Birthplace

N. C.

16. Informant

Mr. D. J. PenningtonAddress Westminster, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 11, 1946
(month) (day) (year)

Cemetery or crematory

Bachman cemetery

Location

Bachman Valley, Md.

18. Funeral director

W. B. Burkard Son

Address

Westminster, Md.

19.

(Date rec'd by registrar)

9/10194611

23. SIGNATURE

John J. Stewart

M. D. or other

Address

Westminster

Date signed

Sept 11, 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1946, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1st 1946, to Sept 7th 1946.and that I last saw her alive on Sept 7th 1946.Immediate cause of death Stroke

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Stewart

M. D. or other

Address

Westminster

Date signed

Sept 11, 1946

RECEIVED

SEP 11 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08916

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Marriottsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CarrollCity or town Marriottsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sarah E. Oursler

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Robert S. Oursler

7. Birth date of deceased (mo., day, yr.)

November 18, 1876

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

69924

hrs.

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

None

FATHER

12. Name

John Richardson

13. Birthplace

MD.

MOTHER

14. Maiden name

Francess Gray

15. Birthplace

MD.

16. Informant

Mr. Robert Oursler

Address

Marriottsville, MD.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

9-14-46

(month) (day) (year)

Cemetery or crematory

Woods Chapel Church

Location

Liberty Road, Balt. Co. MD.

18. Funeral director

C. Harry Wren

Address

Shelburne, MD.

19.

Sept 13 1946

(Date fixed by registrar)

C. Harry Wren

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 1940 to Sept. 12, 1946and that I last saw her alive on Sept. 10, 1946

Immediate cause of death

Cardiovascular Disease

DURATION

Due to

Due to

Other conditions

Diabetes & nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Dr. E. Martin M. D. or otherAddress Randalltown Date signed 9/13/46

RECEIVED

SEP 18 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 782

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Supersville
 City or town Springfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs 9 mo 22 da
 Hospital, institution, or street address where death occurred Springfield State Hospital
 How long in hospital or institution? 2 yrs 9 mo 22 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County ...
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ...
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1876 8. (c) If alive, give age ... years

8. AGE: Years 68 Months ... Days ... If less than one day ... hrs. ... min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation housewife11. Industry or business at home12. Name Baxter13. Birthplace Virginia14. Maiden name ...15. Birthplace Virginia16. Informant Edgar PearceAddress 1234 W 37th St Baltimore

17. Burial Date thereof Sept 23 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Mary'sLocation Hampden18. Funeral director Cheney & DanversAddress 3615-17 Chestnut Ave.

19. Sept 30 1946 C. H. Hays
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19th 1946 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1943 to Sept 19th 1946
 and that I last saw him alive on Sept 19th 1946

Immediate cause of death Chronic Myocarditis DURATION 7 yrsDue to Chronic MyocarditisDue to Chronic MyocarditisOther conditions Chronic Arteriosclerosis DURATION 7 yrsOther conditions Chronic Arteriosclerosis

RECEIVED
SEP 24 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

08918

74



Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 4 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 218 Washington Street
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

EDISON PINDER

3. (b) Social Security Number

217-10-8748

4. Sex <u>male</u>	5. Color or race <u>col.</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
6. (b) Name of husband or wife		
6. (c) If alive, give age _____ years		
7. Birth date of deceased (mo., day, yr.) <u>Unknown 1907</u>		
8. AGE: Years <u>39(?)</u>	Months <u>--</u>	Days <u>--</u> If less than one day _____ hrs. _____ min.
9. Birthplace <u>Cambridge, Md.</u> (Town, county, and state)		
10. Usual occupation <u>Farm Laborer</u>		
11. Industry or business		
12. Name <u>John Pinder</u>		
13. Birthplace <u>Unknown</u>		
14. Maiden name <u>Bertha ?</u>		
15. Birthplace <u>Unknown</u>		

16. Informant Deceased
 Address
 17. Burial Date thereof Sept 7, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
 Location Swiss Boyer
 18. Funeral director Swiss Boyer
 Address Cambridge Md.
 19. Sept. 4, 1946
 (Date rec'd by registrar) Albert R. ...
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1946 at 9:00 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 30, 1946 to Sept. 4, 1946
 and that I last saw him alive on Sept. 4, 1946

Immediate cause of death
Pulmonary Tuberculosis

DURATION
March
1945

Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
 M. D. or other
 Address Henryton, Md. Date signed 9-4-46

SEP 10 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08919

Reg. Dist. No. 82

1. PLACE OF DEATH:

County Carroll
 City or town Ridgeville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Ridgeville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Mt. Airy, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

JOSEPH N. POPE

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Divorced
6.(b) Name of husband or wife		
7. Birth date of deceased (mo., day, yr.) March 2, 1874		
8. AGE: Years 72	Months 6	Days 11 If less than one day hrs. min.

9. Birthplace Montgomery Co. Maryland
 (Town, county, and state)
Laborer

10. Usual occupation

11. Industry or business

12. Name Joseph M. Pope13. Birthplace Maryland14. Maiden name Matilda A. Thompson15. Birthplace Maryland16. Informant Mr. Joseph E. PopeAddress Damascus, Md.17. Burial 9-16-46

(Burial, cremation, entombment, etc.) Date thereof (month) (day) (year)

Cemetery or place of interment GoshenLocation nr. Laytonsville, Md.18. Funeral director C.M. WaltzAddress Winfield, Md.19. Sept. 15 1946 John D. Snyder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946 at 99 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug. 2 1944 to Sept 13 1946and that I last saw him alive on Sept 19 1946

Immediate cause of death

Carcinoma of Stomachwith general metastasisDue to (Advanced)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. WaltzAddress Mt. Airy, Md.Date signed 9/14/46

RECEIVED
SEP 17 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

08921

74

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 4 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County

City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 610 Brant Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

ROSE REED

3. (b) Social Security Number

lost

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife William Reed6. (c) If alive, give age 28 years7. Birth date of deceased (mo., day, yr.) August 17, 1917

8. AGE: Years 29 Months 0 Days 14 If less than one day
 hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Frank Winston13. Birthplace Virginia14. Maiden name Golden Harper15. Birthplace Virginia16. Informant Deceased

Address

17. BURIAL Date thereof 9/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location MT. SALVATOR, MD.
William: Baltimore18. Funeral director 1701 7th St. N.E. Wash

Address

9/11 1946 Albert H. Swann19. (Date rec'd by registrar) 9/11 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 19 46 at 4.00A AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 7, 19 46 to Sept. 11 19 46
 and that I last saw her alive on Sept., 11, 19 46

Immediate cause of death Pulmonary Tuberculosis
 DURATION Jan. 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

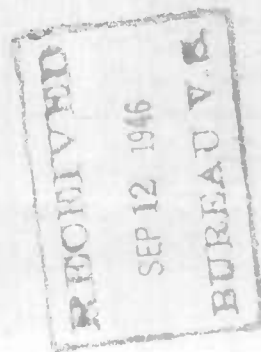
Means of injury Injured at work?

23. SIGNATURE Newton Hoffman M.D. M. D. or otherAddress Henryton, Md. Date signed 9/1/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



COPY SENT TO Co. H. Officer LOCAL REGISTRY NO. 9/13/46 DATE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on FILM No. 107 OCT 8 1946 is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

of deceased is shown on

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08920 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 17 days

Hospital, institution, or street address where death occurred:

Maryland tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1210 N. Central Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WINSTON JAMES RILEY

3. (b) Social Security Number

230-07-2366

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

Marie Riley

7. Birth date of deceased (mo., day, yr.)

July 20, 1917

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

29

39

1

28

hrs.

min.

9. Birthplace

Portsmouth, Va.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

James Riley

13. Birthplace

Portsmouth, Va.

MOTHER

14. Maiden name

Hattie Jones

15. Birthplace

Henneson, N. C.

16. Informant

Deceased

Address

17.

Shipped

Date thereof

9-21-46

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Portsmouth, Va.

Location

18. Funeral director

Robert E. Williams

Address

1515 Mc Elderry St.

9/18

46

Albert R. Swank

(Date rec'd by registrar)

19

Deputy Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1946 at 8.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946 to Sept. 18, 1946

and that I last saw him alive on September 18, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Jan. 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

Robert E. Williams, M.D.

M. D. or other

Address Henryton, Md.

Date signed 9/18/46

RECEIVED
SEP 26 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08922 82

1. PLACE OF DEATH: Carroll
County.....Mt. Airy
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....6 months
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland
State.....County.....Carroll
City or town.....Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME LUCIAN O. RUNKLES

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife.....Laura V. Runkles
deceased
6. (c) If alive, give age.....years
7. Birth date of deceased (mo., day, yr.) Feb'y 10, 1863
8. AGE: Years 83 Months 6 Days 27 If less than one day.....hrs.min.

9. Birthplace.....Frederick Co. Maryland
(Town, county, and state)
Farmer (retired)
10. Usual occupation.....
11. Industry or business.....
12. Name.....William Runkles
13. Birthplace.....Maryland
14. Maiden name.....Barbara Harding
15. Birthplace.....Maryland

16. Informant.....Mr. Edward L. Runkles
Address.....Mt. Airy, Maryland
Burial.....9-10-46
(Burial, cremation, or removal, which?) (month) (day) (year)
Prospect
Cemetery or crematory.....
Nr. Mt. Airy, Frederick Co. Md.
Location.....C. M. Waltz
18. Funeral director.....Winfield, Md.
Address.....
19. 9/9 46 Jm D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Sept 7 1946 at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1946 to Sept 7 1946
and that I last saw him alive on Sept 5 1946

Immediate cause of death.....Acute Endocarditis
DURATION.....
Due to.....Ascites and hypertension 4 days
Due to.....
Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide.....Date of.....
Where did injury occur?.....(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury.....Injured at work?
23. SIGNATURE.....C. M. Waltz
M. D. or other
Address.....Mt Airy Md
Date signed.....9/8/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 11 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

08923

Reg. Dist. No.

24

1. PLACE OF DEATH:

County..... Carroll
City or town..... Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yr., 9 mo., 21 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 yr., 9 mo., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County.....
City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1122 William Street
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Edward Adolph Sadler

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Katherine Aner
7. Birth date of deceased (mo., day, yr.) June 5, 1872 6. (c) If alive, give age years
8. AGE: Years 74 Months 2 Days 28 hrs. min.

9. Birthplace Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation salesman
11. Industry or business
12. Name John C.H. Sadler
13. Birthplace Maryland
14. Maiden name Hughes
15. Birthplace Rhode Island

16. Informant Springfield State Hospital Records
Address Sykesville, Maryland
17. Burial Date thereof 9-6-46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Holy Cross Cem.
Location Baltimore Md.
18. Funeral director E. Lynn & Son
Address 1436 Light St.
19. Date rec'd by registrar Sept 3 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1946 at 5:40A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Sept. 3 1946
and that I last saw him alive on September 2 1946
Immediate cause of death Arteriosclerosis DURATION 5 yrs.
Due to.....
Due to.....
Other conditions Psychosis with chronic alcoholism, deterioration 5 years
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury Injured at work?
Robert Bertrand May, M.D.
23. SIGNATURE Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Sykesville, Maryland Date signed 9-3-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-6

CERTIFICATE OF DEATH

Reg. Dist. No. 74

08924

1. PLACE OF DEATH:

County CarrollCity or town Henryton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mos.Hospital, institution, or street address where death occurred: MarylandTuberculosis Sanatorium (Colored.)How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Marion Station
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 1, Box 103
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Gladys Savage

3.(b) Social Security Number

4. Sex

female

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

January 19, 1927

6.(c) If alive, give age years

8. AGE:

Years

19

Months

7

Days

24

If less than one day

hrs. min.

9. Birthplace Marion Station, Md.

(Town, county, and state)

10. Usual occupation factory worker

11. Industry or business

FATHER

12. Name Marion Savage13. Birthplace Marion Station, Md.

MOTHER

14. Maiden name Celia Robinson15. Birthplace Westover, Md.16. Informant Reuben Hoffman, M.D.Address Henryton, Md.17. Buried Date thereof Sept. 15, 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Kingston CemeteryLocation Marion Station18. Funeral director Geo W. SelburnAddress Marion St. Md.19. Sept. 13 46
(Date rec'd by registrar) deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1946 at 12:25 ^P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 13 1946 to Sept. 13 1946and that I last saw her alive on Sept. 13 1946

Immediate cause of death

Pulmonary tuberculosis

DURATION

Feb. 46

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or otherAddress Henryton, Md. Date signed 9-13-46

RECEIVED
SEP 19 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08925
74

1. PLACE OF DEATH:
County... Carroll
City or town... Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 1 mo., 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County...
City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 743 Dolphin St.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

JOSEPH DOUGLAS SCRIBER

3. (b) Social Security Number

214-16-7548

4. Sex male 5. Color or race col. 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Florence Scriber
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) July 8, 1919
8. AGE: Years 27 Months 1 Days 28 If less than one day..... hrs. min.

9. Birthplace Hollywood, Md.
(Town, county, and state)

10. Usual occupation Stevadore

11. Industry or business

FATHER 12. Name James Scriber

13. Birthplace Hollywood, Md.

MOTHER 14. Maiden name Nettie Lyles

15. Birthplace Hollywood, Md.

16. Informant Deceased

Address

17. Burial Date thereof 9/9/46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Johns

Location St. Mary's County Md

18. Funeral director Mrs. Kate R. Willman

Address 222 N. Schaeffer St.

19. Sept. 6, 1946
(Date rec'd by registrar) Alfred R. Saxton
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1946, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12, 1944, to Sept. 6, 1946, and that I last saw him alive on Sept. 6, 1946.

Immediate cause of death Pulmonary Tuberculosis DURATION May 1, 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Richard W. Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 9-6-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
SEP 9 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

CERTIFICATE OF DEATH

08926 76
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Carroll
 City or town..... rural Westminster (Reese)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 18 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll
 City or town..... rural Westminster (Reese)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ann Marie Shipley

3. (b) Social Security Number

215-20-8326

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>female</u>	<u>white</u>	<u>single</u>

6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) October 29, 1926
 8. AGE: Years Months Days If less than one day
19 10 28 hrs. min.

9. Birthplace..... Baltimore County, Maryland
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Sterling A. Shipley
 13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Mary Weaver
 15. Birthplace..... Maryland

16. Informant..... Mary Weaver Shipley
 Address..... Westminster, Md.

17. burial Date thereof..... 9/28/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Westminster Cemetery
 Location..... Westminster, Md.

18. Funeral director..... J. Francis Reese
 Address..... Westminster, Md.

19. 27 46 Day For
 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 26 19..... 46 at..... 9:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1 19..... 46 to..... Sept 26 19..... 46
 and that I last saw him/her alive on..... Sept 26 19..... 46

Immediate cause of death.....
Acute tuberculosis
lungs & intestines involved
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... E. Reese Wilkins
 Address..... Westminster Date signed..... 9/26/46
 M. D. or other

RECEIVED
OCT 4 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195

CERTIFICATE OF DEATH

08927 74
Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 3 mo's, 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ✓
2.(a) If veteran, name war _____

3. (a) FULL NAME

AGNES CHRISTINE SIMMS

3. (b) Social Security Number

None

4. Sex

female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

November 7, 1920

8. AGE:

Years

25

Months

10

Days

0

If less than one day

_____ hrs. _____ min.

9. Birthplace

Leeland, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Mary E. Savoy

15. Birthplace

Unknown

16. Informant

Deceased

Address

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

9/7

19 46

Deputy Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1946 at 8.15P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 27 1944 to Sept. 7, 1946
and that I last saw her alive on Sept. 7, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Aug.
1943

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Reuben Hoffman, M.D.
M. D. or other

Address

Henryton, Md.Date signed 9/7/46

RECEIVED
SEP 16 1946
BUREAU V. B.

1/16 Training to 'Vol' 9-11-41

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74-0)

CERTIFICATE OF DEATH

08929

Reg. Dist. No. 71

1. PLACE OF DEATH:

County... Carroll
 City or town... rural Westminster (Mayberry)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Carroll
 City or town... rural Westminster (Mayberry)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Route 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ernest Raymond Stocksdales

3. (b) Social Security Number

220-07-1350

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Gertrude Connersmith
 6.(c) If alive, give age 51 years
 7. Birth date of deceased (mo., day, yr.) March 17, 1890
 8. AGE: Years 56 Months 6 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace... Carroll County, Maryland
 (Town, county, and state)
 10. Usual occupation... Clerk
 11. Industry or business Retail store
 12. Name... Noah M. Stocksdales
 13. Birthplace Maryland
 14. Maiden name... Martha Davis
 15. Birthplace Maryland

16. Informant... Mrs. Ernest R. Stocksdales
 Address Westminster, Md. R. #1.

17. burial Date thereof 10/3/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Sandy Mount Cemetery
 Location... Sandyville, Md.

18. Funeral director... J. Francis Reese
 Address Westminster, Md.

19. Oct 3 46 Registrar Margaret Engle
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946 at 8:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to Sept 30 1946
 and that I last saw him alive on Sept 28 1946

Immediate cause of death Coronary disease
 DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ernest R. Stocksdales M. D. or other _____Address Westminster Md Date signed 10/1/46

RECEIVED

OCT 10 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

08930

Reg. Dist. No. 75

1. PLACE OF DEATH

County... Westminster 4th P.D. #3
City or town...
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Katharine Irene Swartz

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Charles Swartz
7. Birth date of deceased (mo., day, yr.) Jan 28 1904 6. (c) If alive, give age 44 years

8. AGE: Years 43 Months 7 Days 14 If less than one day hrs. min.

9. Birthplace York Co Pa
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Ros Fleming

13. Birthplace York Co Pa

14. Maiden name Wells

15. Birthplace York Co Pa

16. Informant Charles H. Swartz

Address Westminster 4th P.D. #3

17. Burial (Burial, cremation, or removal) Burial Date thereof Sept 16 1946
(month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Harveys Pa

18. Funeral director McKee

Address Harveys Pa

19. Sept 15 46 Mrs. W. R. S. Deemer
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State... Pa County... Carroll
City or town... Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No... P.D. #3
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1946 to Sept 13 1946
and that I last saw him alive on Sept 11 1946

Immediate cause of death Coronary thrombosis

Due to Cardiac arrhythmia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mark W. Reading MD
M. D. or other

Address Harveys Pa Date signed 9/14/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1946

BUREAU V K

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

08931

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll
 City or town... Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 month, 13 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Anne Arundel
 City or town... Furnace Branch
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. #9, Box 135,
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

LAURA SAVOY TAYLOR

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Winfield Taylor
 8.(c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) February 22, 1903
 8. AGE: Years 43 Months 6 Days 25 It less than one day _____ hrs. _____ min.

9. Birthplace Eldersburg, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name Alpheus Thomas
 13. Birthplace Carroll County, Md.
 14. Maiden name Bessie Dorsey
 15. Birthplace Howard County, Md.

16. Informant Deceased

Address

17. Burial Date thereof 9-19-46
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory White Rock

Location Barnett Carroll & Ind.

18. Funeral director E. M. Waltz

Address Winfield Ind

19. 9/17 19. 46 Albert R. Lewis
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1946 at 1.00A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4, 1946 to Sept. 17, 1946 and that I last saw him alive on September 17, 1946

Immediate cause of death Pulmonary Tuberculosis
 DURATION April 1941

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Newton Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 9/17/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 19 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH: Carroll
County.....
City or town..... R.D. Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County..... Carroll
City or town..... R.D. Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Sidney Thomas

3. (b) Social Security Number
220-24-7280

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1914
6. (c) If alive, give age..... years

8. AGE: Years 31 Months 8 Days 17 If less than one day
..... hrs. min.

9. Birthplace Columbus, Ohio
(Town, county, and state)
Laborer

10. Usual occupation B. & O. R.R.

11. Industry or business William H. Thomas

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden name Elizabeth Waters
15. Birthplace

16. Informant Mrs. Dessie Williams
Address Mt. Airy, Md.

Burial 9-18-46
(Burial, ~~cremation~~, or other. Which?) Date thereof (month) (day) (year)
Cemetery or ~~crematory~~ Mt. Zion
Location nr. Mt. Airy, Carroll Co. Md.
C.M. Waltz

18. Funeral director Winfield, Md.
Address

19. Date rec'd by registrar 9-17-46 J. H. Dwyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19..... 10..... 19.....
and that I last saw him alive on 18.....

Immediate cause of death
Gunshot wound chest

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide, Homicide Date of 9-15-46

Where did injury occur? nr. Mt. Airy Carroll Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gunshot wound Injured at work? no

23. SIGNATURE J. H. Dwyer, Medical Examiner
M. D. or other

Address Testimony Md. Date signed 9-15-46

RECEIVED
SEP 18 1945
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-3

08933

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

County CarrollCity or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 5 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 N. Carey St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JAMES MOLLAR THOMPKINS

3. (b) Social Security Number

213-07-9461

4. Sex

male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 25, 1905

8. AGE: Years Months Days If less than one day

40 9 25 hrs. min.9. Birthplace Wakefield, Va.

(Town, county, and state)

10. Usual occupation Loader in Steel Mill

11. Industry or business

12. Name Eddie Thompson13. Birthplace Wakefield, Va.14. Maiden name Laura Jones15. Birthplace Unknown16. Informant Deceased

Address

17. Shipped Date thereof 9-23-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wakefield, Va.

Location

18. Funeral director Elmer WilsonAddress 1000 Brentley Ave. Balt., Md.9-20-46

19. (Date rec'd by registrar)

Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1946 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 15, 1946 to Sept. 20, 1946and that I last saw him alive on Sept. 20, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

July 6, 1946

Due to

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Richard Hoffman M.D.

M. D. or other

Address Henryton, Md.Date signed 9-20-46

RECEIVED
SEP 26 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-1

CERTIFICATE OF DEATH

Reg. Dist. No. 08934 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months, 22 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1227 E. Madison Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

MABEL JOSEPHINE UTSEY

3. (b) Social Security Number

4. Sex female 5. Color or race col. 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 28, 1928

8. AGE: Years 18 Months 2 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Grover, S.C.
 (Town, county, and state)

10. Usual occupation Scholar

11. Industry or business _____

12. Name Alonza Utsey13. Birthplace South Carolina14. Maiden name Mamie Griffin15. Birthplace South Carolina16. Informant Deceased

Address _____

17. Shipped Date thereof 9-22-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Georges, S.C.

Location _____

18. Funeral director Mrs. Robert Elliott DaughierAddress 1127 N. Caroline St.

19. Sept. 19, 46
 (Date rec'd by registrar) Albert R. Swann Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1946 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1946 to Sept. 19, 1946
 and that I last saw him/her alive on September 19, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION Feb. 1946

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert E. Hoffman, M.D. M. D. or other

Henryton, Md. Date signed 9-19-46

BUREAU V.B.
SEP 26 1946
RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

08935

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll

City or town... Jessupville

How long in above place of death? 3 yrs 6 mo 24 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution? 3 yrs 6 mo 24 da

3. (a) FULL NAME

Henry Logelsang

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

Aug 13 th 1872

8. AGE:

Years

74

Months

21

Days

hrs.

min.

If less than one day

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years 8 months 10 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 3 years 8 months 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war

3. (a) FULL NAME

John Francis Walsh

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Susan Theresa Flaherty
 7. Birth date of deceased (mo., day, yr.) April 25, 1867 6.(c) If alive, give age years
 8. AGE: Years 79 Months 4 Days 27 If less than one day hrs. min.

9. Birthplace Baltimore City, Maryland
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name John Francis Walsh

13. Birthplace Ireland

MOTHER 14. Maiden name Bridget McHale

15. Birthplace Ireland

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial Date thereof Sept. 26/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Old Frederick Rd.

Location John A. Moran

18. Funeral director 3000 E. Balto. H.

Address 9/24/46

19. Q. W. Hedrick Registrar
 (Date rec'd by registrar) 19.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 19 46 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 46 to Sept. 22 19 46
 and that I last saw h. im alive on September 21 19 46

Immediate cause of death Arteriosclerosis DURATION 7 yrs.

Due to

Due to

Other conditions Psychosis with arterio-sclerosis 7 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Howard N. Frederickson, M.D.

23. SIGNATURE Howard N. Frederickson

Springfield State Hospital M. D. or other

Sykesville, Maryland Date signed 9-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08937 74

1. PLACE OF DEATH:

County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1826 E. Biddle Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

HERENDON WHITAKER

3. (b) Social Security Number

4. Sex male 5. Color or race col. 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 15, 1912 8.(c) If alive, give age years

8. AGE: Years 34 Months 1 Days 19 If less than one day hrs. min.

9. Birthplace Enfield, N.C.
(Town, county, and state)

10. Usual occupation Waiter

11. Industry or business

12. Name James Whitaker

13. Birthplace Enfield, N.C.

14. Maiden name Ella Scott

15. Birthplace Enfield, N.C.

16. Informant Deceased

Address

17. (Burial, cremation, or removal. Which?) Shipped Date thereof 9/9/46
(month) (day) (year)

Cemetery or crematory Deer Creek Cem

Location Enfield, N.C.

18. Funeral director Elroy O. Wilson

Address 1000 Brantly ave

19. Sept. 9, 1946 Deputy Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1946 at 9:45P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1946 to Sept. 4, 1946 and that I last saw him alive on Sept. 4, 1946

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other

Address Henryton, Md. Date signed 9-4-46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED
SEP 16 1946
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ba)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Carroll
 City or town..... Rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
 Springfield State Hospital
 How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2211 Orleans Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph
James/White

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

married

6.(b) Name of husband or wife

Carrie Lutche

7. Birth date of
deceased (mo., day, yr.)

January 7, 1882

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

64

8

--

..... hrs.

..... min.

9. Birthplace..... Baltimore City, Maryland

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

City maintenance depts.

FATHER

12. Name

Matthew White

13. Birthplace

Maryland

MOTHER

14. Maiden name

Fanny Murdock

15. Birthplace

Maryland

16. Informant..... Springfield State Hospital Records

Address

Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)Date thereof 9/11/46
(month) (day) (year)Cemetery or crematory
xxxxx Holy RedeemerLocation
4430 Belair Rd. Baltimore, Md.

18. Funeral director

Charles E. Schimunek

Address

2601-03 E. Madison Street

19. 9/10/46
(Date rec'd by registrar)

19

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1946 10:20pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 9 1944 to Sept. 7 1946

and that I last saw him alive on September 7 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

16 hrs.

Due to Arteriosclerosis

6 yrs.

Due to

Other conditions Psychosis with cere-
bral arteriosclerosis

6 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.

Springfield State Hospital
Sykesville, Maryland

M. D. or other

Address..... Date signed 9-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B2

CERTIFICATE OF DEATH

Reg. Dist. No. 1189374

1. PLACE OF DEATH:

County Carroll
 City or town Henryton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 months, 19 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1526 Druid Hill Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EDITH LORRAINE WILSON

3. (b) Social Security Number

4. Sex

female

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 4, 1924

8. AGE:

Years

Months

Days

If less than one day

22519

hrs. min.

9. Birthplace

Burkeville, Va.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

John Wilson

13. Birthplace

Virginia

MOTHER

14. Maiden name

Mary Williams

15. Birthplace

Virginia

16. Informant

Deceased

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Sept. 23, 1946
 (Date rec'd by registrar)

Deputy Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1946 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 4, 1946, to Sept. 23, 1946.and that I last saw her alive on September 23, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Dec.1945

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henryton, Md.

M. D. or other

Address Date signed 9-23-46

RECEIVED

SEP 25 1946

BUREAU OF